# Revised Core Services Taxonomy 6

## December 1, 2002

***Revised***

***May 5, 1995***
***May 8, 1998***
***February 2, 1999***
***May 2, 2000***
***April 27, 2001***
***December 28, 2001***
***December 1, 2002***
***April 28, 2003***
***May 12, 2004***

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## Notes on the Dated Revisions of the Taxonomy

**May 8, 1998**: This revision added ***Motivational Treatment Services*** as a substance abuse outpatient subcategory.

**February 2, 1999:** This revision updated the taxonomy to reflect changes in Chapter 10 of Title 37.1 of the *Code of Virginia* that were enacted with the passage of House Bill 428 in 1998.

**May 2, 2000:** This revision added ***Consumer Monitoring Services*** as a new subcategory in the **Outpatient and Case Management Services** category, primarily in the mental retardation and mental health program areas.

**April 27, 2001:** This revision added ***Medical Services*** as a new subcategory in **Outpatient and Case Management Services** and ***Jail-Based Habilitation Services*** as a new subcategory in **Residential Services**, added *Housing Subsidies* as a new type of ***Supportive Residential Services***, and inserted CARS-ACCESS codes for all community services in the Taxonomy for reference purposes.

**December 28, 2001:** This revision added *Community Gero-psychiatric Residential Services* as a new type of ***Highly Intensive Residential Services***.

**December 1, 2002:** This revision added ***definitions*** of terms formerly contained in the Community Services Performance Contract.

**April 28, 2003:** This revision added quality improvement and risk management to the definition of **Administrative and Management Expenses**.

**May 12, 2004:** This revision

1. corrects some inconsistencies in the names of various core service subcategories;
2. adds the Community Consumer Submission (CCS) codes for Discharge Assistance Projects (DAP), Non-CSA Mandated Mental Health Child and Adolescent Services, Programs of Assertive Community Treatment (PACT), Medicaid Mental Retardation Home and Community-Based Waiver Services, and Substance Abuse State Mental Health Facility Admission Diversion Projects on page 14;
3. updates Types of Community Services Boards on page 5 to reflect the current Overview of Community Services in Virginia;
4. moves Medical Services (311) into Outpatient Services, reflecting the change in the FY 2004 performance contract;
5. revises the definition of Assertive Community Treatment to reflect the definition of Intensive Community Treatment that replaces it, PACT is now handled with a CCS 900 code (page 14);
6. revises the definition of *Supervised Apartments* to delete ". . . in units that are owned, rented, leased, or otherwise controlled by the licensed service provider." since this has caused some confusion and is not essential to the definition;
7. includes the priority population screening criteria in Appendix A so that the criteria are more easily accessible (previously, the criteria were only in the classification forms that were last available in the FY 2003 performance contract);
8. incorporates the MR Waiver Crosswalk, which links Waiver services to the Taxonomy, in Appendix B and includes abridged definitions from DMAS regulations of Medicaid Mental Retardation Home and Community-Based (HCB) Waiver services in Appendix C; and
9. revises the definition of bed day to permit counting partial bed days for social detoxification, a highly intensive residential service.

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## Introduction

The idea of core services emerged from the General Assembly's Commission on Mental Health and Mental Retardation in 1980. The first list of core services, developed in response to a Commission recommendation, contained five categories of services: emergency, inpatient, outpatient and day support, residential, and prevention and early intervention. The State Mental Health, Mental Retardation and Substance Abuse Services Board approved the original core services definitions in 1981. The General Assembly accepted general definitions of these services and amended § 37.1-194 of the *Code of Virginia* in 1984 to list those services. Then, that section required only the provision of emergency services; other services were not mandated. In 1998, the General Assembly added a second mandated service, case management, but qualified the requirement with this condition, ". . . case management services subject to such funds as may be appropriated therefor, . . ."

The initial description of core services established a useful conceptual framework for Virginia's network of community and state facility services. However, it was too general and not sufficiently quantifiable for meaningful data collection and analysis. The initiation of performance contracting in Fiscal Year (FY) 1985 revealed the need for detailed, consistent, and measurable information about services and consumers. Experience with the first round of contracts reinforced the need for core services descriptions that were sufficiently differentiated to reflect the variety of programs or types of services within each category and yet were general enough to encompass the broad diversity of service modalities in Virginia. That experience also established the need for basic, quantified data about services, collected and reported uniformly and comparably.

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Association of Community Services Boards developed the first version of a core services taxonomy, a classification and definition of services, to address these needs. The original version was used for the FY 1986 and 1987 community services performance contracts. The State Mental Health, Mental Retardation and Substance Abuse Services Board promulgated a policy on core services in 1987. The policy states that the current version of the taxonomy will be used to classify, describe, and measure the services delivered by all community services boards (CSBs) and state facilities.

A revised Core Services Taxonomy was produced for the FY 1988 and 1989 contracts. A third version was used for FY 1990 and 1991, a fourth was developed for FY 1992 and 1993, and Core Services Taxonomy 5 was used for the FY 1994 and 1995 contracts. The Department and Association prepared Core Services Taxonomy 6 for use in FY 1996 and subsequent years. Since then, it has been updated with minor revisions several times. The current version, Revised Core Services Taxonomy 6, maintains the six core services categories: emergency, inpatient, outpatient and case management, day support, residential, and prevention and early intervention. It also includes 30 subcategories, different types of similar services within various core services categories, four fewer subcategories than were in Core Services Taxonomy 5. The reduction was achieved by clustering a number of similar services into fewer subcategories in the day support and residential services categories.

The taxonomy categories and subcategories are intended to be inclusive rather than narrowly exclusive. They are not meant to capture everything a CSB or state facility does. The taxonomy categories and subcategories are meant to allow meaningful and accurate descriptions and comparisons of service delivery activities, by CSB, region, state facility, and system wide. This helps produce valid and informative analyses and comparisons among various system components.

Because of the diversity and variety that characterize Virginia's localities and the mix and availability of resources and services from other public and private providers, each CSB may not need to develop or provide services in every subcategory of the core services taxonomy. The list of subcategories does not constitute additional mandates for CSBs; only emergency and case management services are now required. Similarly, each state facility will not need to develop or provide services in every subcategory of the inpatient services category. Finally, this core services taxonomy, including the services definitions, subcategories, levels of service, performance contract definitions, and other elements, will continue to evolve in response to future changes in the organization and operation of state facility and community services in Virginia.

The following graphic portrays the relationship of the core services categories and subcategories in the taxonomy to the more traditional organizational structure of community services.

## Community Services Board (CSB), Behavioral Health Authority (BHA), or Local Government Department with a Policy-Advisory CSB

PROGRAM AREA (all mental health, mental retardation, or substance abuse services)

*Core Service Category* (e.g., residential services)

*Core Service Subcategory* (e.g., intensive residential services)

Individual Program (e.g., a particular group home)

Discrete Service Activities (e.g., meal preparation)

The bolded numbers after the core services categories and subcategories in the definitions section are the Community Automated Reporting System (CARS) and Community Consumer Submission (CCS) codes for the services. For example, within the **Inpatient Services** category, coded as **(200)**, ***Acute Psychiatric or Substance Abuse Inpatient Services*** are coded as **(250)**.

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## Types of Community Services Boards

A particularly meaningful classification of CSBs is the relationship between the CSB and its local government or governments. While CSBs are agents of the local governments that established them, most CSBs are not city or county government departments. The 1998 General Assembly amended §§ 37.1-194 and 194.1 of the *Code of Virginia* to define three types of community services boards (CSBs). Chapter 15 of Title 37.1 of the *Code of Virginia* authorizes BHAs to provide community services. Throughout this Taxonomy, the term community services board and the acronym CSB will include these other organizations.

***Operating CSB*** means the public body, organized in accordance with the provisions of Chapter 10 of Title 37.1 of the *Code of Virginia*, that is appointed by and accountable to the governing body of each city and county that established it for the direct provision of mental health, mental retardation, and substance abuse services. Operating CSB denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in §§ 37.1-197 and -197.1 of the *Code of Virginia*. Operating CSB also includes the organization that provides such services, through its own staff or through contracts with other providers, unless the specific context indicates otherwise. Operating CSBs employ their own staff and are not city or county government departments. There are 28 operating CSBs.

***Administrative Policy CSB*** means the public body, organized in accordance with the provisions of Chapter 10 of Title 37.1 of the *Code of Virginia*, that is appointed by and accountable to the governing body of each city and county that established it to set policy for and administer the provision of mental health, mental retardation, and substance abuse services. Administrative Policy CSB denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in §§ 37.1-197 and -197.1 of the *Code of Virginia*. Mental health, mental retardation, and substance abuse services are provided through local government staff or through contracts with other organizations and providers. Administrative Policy CSBs do not employ their own staff. There are 10 administrative policy CSBs; seven are city or county government departments; three are not, but they use local government staff to provide services.

***Policy-Advisory CSB*** means the public body, organized in accordance with the provisions of Chapter 10 of Title 37.1 of the *Code of Virginia*, that is appointed by and accountable to the governing body of each city and county that established it to provide advice on policy matters to the local government department that provides mental health, mental retardation, and substance abuse services directly or through contracts with other providers pursuant to §§ 37.1-197 and -197.1 of the *Code of Virginia*. Policy-Advisory CSB denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in § 37.1-197 of the *Code of Virginia*. The CSB has no operational powers or duties; it is an advisory board to a local government department. There is one local government department with a policy-advisory CSB, the Portsmouth Department of Behavioral Healthcare Services.

***Behavioral Health Authority*** (BHA) means a public body and a body corporate organized in accordance with the provisions of Chapter 15 of Title 37.1 that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, mental retardation, and substance abuse services. BHA also includes the organization that provides such services through its own staff or through contracts with other organizations and providers, unless the specific context indicates otherwise. Chapter 15 authorizes Chesterfield, Richmond, and Virginia Beach to establish a BHA; a BHA now exists only in Richmond. In many ways, a BHA most closely resembles an operating CSB, but it has several powers or duties, listed in § 37.1-248 of the *Code of Virginia*, that are not given to CSBs.

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## Core Services Definitions: Categories and Subcategories of Services

1. **Emergency Services (100)** are unscheduled, and in some instances scheduled (e.g., crisis stabilization), mental health, mental retardation, or substance abuse services, available 24 hours per day and seven days per week, that provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face, if indicated, to people seeking such services for themselves or others. Emergency services may include walk-ins, home visits, and jail interventions and pre-admission screenings or other activities that prevent admission to a mental health or mental retardation facility or are associated with the judicial admission process. Emergency Services also include Medicaid Mental Retardation Home and Community-Based (HCB) Waiver Crisis Stabilization and Personal Emergency Response System Services.

2. **Inpatient Services (200)** deliver mental health, mental retardation, or substance abuse services on a 24-hour per day basis in a hospital or training center setting.

    a. ***Medical/Surgical Care*** provides acute medical treatment or surgical services in state facilities. Such services may include medical detoxification, orthopedics, oral surgery, urology, care for pneumonia, post-operative care, ophthalmology, ear, nose and throat care, and other intensive medical services.

    b. ***Skilled Nursing Services*** deliver medical care, nursing services, and other ancillary care for people with mental disabilities who are in state facilities and require nursing as well as other care. Skilled nursing services are most often required by persons who are acutely ill or have severe or profound mental retardation and by those elderly individuals with mental illness who suffer from chronic physical illnesses and loss of mobility. These services are provided by professional nurses, licensed practical nurses, and qualified paramedical personnel under the general direction and supervision of a physician.

    c. ***Intermediate Care Facility/Mentally Retarded (ICF/MR) Services*** are provided in state training centers for people with mental retardation who require active habilitative and training services, including respite and emergency care, but not the degree of care and treatment provided in a hospital or skilled nursing home.

    d. ***Intermediate Care Facility/Geriatric Services*** are provided in state geriatric facilities by interdisciplinary teams to patients who are 65 years of age and older. These services include psychiatric treatment, medical treatment, personal care, and therapeutic programs appropriate to the facility and the patient's needs.

    e. ***Acute Psychiatric or Substance Abuse Inpatient Services*** **(250)** provide intensive short-term psychiatric treatment in state mental health facilities and intensive short-term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except for detoxification, in local hospitals. CSBs support local services through contractual arrangements. These services may include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

    f. ***Community-Based Substance Abuse Medical Detoxification Inpatient Services*** **(260)** use medication under the supervision of medical personnel in local hospitals or other 24 hour per day care facilities to systematically eliminate or reduce effects of alcohol or other drugs in the body.

    g. ***Extended Rehabilitation Services*** offer intermediate or long-term treatment in a state mental health facility for individuals with severe psychiatric impairments, emotional disturbances, or multiple handicaps (e.g., people with mental illnesses who also are deaf).

These services may include rehabilitation training, skills building, and behavioral management for people who are beyond the crisis stabilization and acute treatment stages.

3. **Outpatient and Case Management Services (300)** provide mental health, mental retardation or substance abuse services, generally in sessions of less than three consecutive hours, to individuals in a non-residential setting.

   a. ***Outpatient Services*** **(310)** are generally provided to consumers on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include the provision of psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, and nurses and the cost of medications purchased by the CSB and provided to consumers. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Outpatient Services also include Medicaid Mental Retardation HCB Waiver Skilled Nursing Services and Therapeutic Consultation Services.

   This subcategory also includes *intensive substance abuse outpatient services* that are provided generally in a concentrated manner over a four to 12 week period for consumers requiring intensive outpatient stabilization, such as people with severe psychoactive substance use disorders. Usually, intensive outpatient services include multiple group therapy sessions during the week plus individual and family therapy, consumer monitoring, and case management.

   b. ***Intensive In-home Services*** **(315)** are time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

   c. ***Motivational Treatment Services*** **(318)** are generally provided to consumers on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help a consumer resolve his or her ambivalence about changing problematic behaviors by using a repertoire of data-gathering and feedback techniques. Motivation treatment is not a part of another service; it stands alone. Its singular focus on increasing the consumer's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes motivation treatment from other outpatient services. A course of motivational treatment may involve a single session, but more typically four or eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the consumer's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. Such an assessment may also follow a course of motivational treatment to ascertain any changes in the consumer's readiness for change.

   d. ***Methadone Detoxification Services*** **(330)** combine outpatient treatment with the administering or dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug free state in a period not to exceed 180 days.

e. ***Opioid Replacement Therapy Services*** **(340)** combine outpatient treatment with the administering or dispensing of synthetic narcotics approved by the federal Food and Drug Administration for the purpose of replacing use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

f. ***Case Management Services*** **(320)** assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

g. ***Intensive Community Treatment*** **(350)** is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; (2) minimally refers individuals to outside service providers; (3) provides services on a long-term care basis with continuity of caregivers over time; (4) delivers 75 percent or more of the services outside of program offices; and (5) emphasizes outreach, relationship building, and individualization of services. Intensive Community Treatment (ICT) is a less concentrated level of service than a Program of Assertive Community Treatment (PACT), which has a higher staffing ratio. ICT is a bundled service with an established Medicaid reimbursement rate; PACT is an array of discrete but integrated services that are billed separately. Individuals served by Intensive Community Treatment (ICT) have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. This also could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of mental retardation. ICT provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. ICT may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills

h. ***Consumer Monitoring Services*** **(390)** are provided to consumers who have been admitted to the CSB but who will not receive any other services or be counted as active cases; their cases will remain inactive indefinitely. Two groups of individuals might receive consumer monitoring services. The first group is individuals who have been admitted to the CSB and assigned a case manager, but they have not been enrolled in a service. Instead, they have been placed on waiting lists for services. They receive no interventions or face-to-face contact in more than 180 days, but they do receive consumer monitoring services, which typically consist of service coordination or intermittent emergency contacts, at least once every 360 days. The second group is individuals who receive outreach services, such as outreach contacts with homeless persons, from the CSB; but they have not been enrolled yet in CSB services. For purposes of the performance contract and reports, the numbers of these consumers and the consumer service hours that are provided to them are projected and reported.

4. **Day Support Services (400)** provide structured programs of mental health, mental retardation, or substance abuse treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in a non-residential setting. *Italicized services* described in some of the following subcategories are included only for illustrative purposes.

   a. ***Day Treatment/Partial Hospitalization*** **(410)** is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental illnesses or alcohol or other drug abuse disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services.

   b. ***Therapeutic Day Treatment for Children and Adolescents*** **(415)** is a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or children (birth through age 17) at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

   c. ***Rehabilitation*** **(425)** programs include various training opportunities in two modalities.

      *Psychosocial Rehabilitation* programs provide certain basic opportunities and services - assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy - in a supportive community environment focusing on normalization. It emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.

      *Day Health and Habilitation* programs provide planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with mental retardation to improve their condition or maintain an optimal level of functioning. Specific components of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation.

      This subcategory also includes Medicaid Mental Retardation HCB Waiver Day Support (Center-Based and Non-Center- Based) and Prevocational Services.

   d. ***Sheltered Employment*** **(430)** programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service also includes the development of social, personal, and work-related skills based on an individualized consumer service plan.

   e. ***Supported Employment-Group Model*** **(465)** programs provide work to a small group of three to eight individuals at a job site in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting to have regular contact with non-disabled individuals who are not providing support services. The employer or the vendor of supported employment services employs the consumers. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the consumer's individual written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. This subcategory also includes Medicaid MR HCB Waiver Supported Employment - Group Model.

f. ***Transitional or Supported Employment*** **(460)** provides two types of paid employment.

*Transitional Employment* programs involve a sequence of temporary supported placements that result in a final competitive employment placement with or without supports. Service units may be shown as a separate activity here or included as part of another program (e.g., psychosocial rehabilitation), depending on how the service is delivered and its relative volume.

*Supported Employment-Individual Placement Model* programs provide work to a consumer placed in an integrated work setting in the community. The employer employs the consumer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan.

This subcategory (***Transitional or Supported Employment*****)** also includes Medicaid MR HCB Waiver Supported Employment - Individual Model.

g. ***Alternative Day Support Arrangements*** **(475)** are day support alternatives, which are not included in preceding subcategories, that assist people to locate day support settings and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting the person to maintain an independent day support arrangement. This subcategory includes *Education/Recreation Services* that provide education, recreation, enrichment, and leisure activities daily, weekly, or monthly, during the summer or throughout the year.

5. **Residential Services (500)** provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services. Specific services (e.g., group homes) that were subcategories in Taxonomy 5 cluster in some of the following subcategories. Information about numbers of consumers served, units of services, and expenses are projected and reported only at the subcategory level. *Italicized services* described in some of the following subcategories are included only for illustrative purposes.

a. ***Highly Intensive Residential Services*** **(501)** provide **overnight care ~~in conjunction~~ with intensive treatment or training services**. These services include: mental health residential treatment centers such as short term intermediate care, crisis stabilization, residential alternatives to hospitalization, and residential services for individuals with dual diagnoses (e.g., mental retardation with co-occurring mental illness) where intensive treatment rather than just supervision occurs; Intermediate Care Facilities for Mentally Retarded persons (ICF/MR) that deliver active habilitative and training services in a community setting; and social detoxification programs in specialized non-medical facilities with physician services available when required that systematically reduce or eliminate the effects of alcohol or other drugs in the body, return a person to a drug-free state, and normally last up to seven days. This subcategory also includes *Community Gero-psychiatric Residential Services* that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental illness, behavioral problems, and concomitant health problems (usually age 65 and older), appropriately treated in a geriatric setting, receive intense supervision, psychiatric care, behavioral treatment planning, nursing, and other health-related services.

b. ***Intensive Residential Services*** **(521)** provide **overnight care with treatment or training that is less intense than the first subcategory**. This subcategory includes the following services and Medicaid Mental Retardation Home and Community-Based (HCB) Waiver Congregate Residential Support Services.

*Primary Care* offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.

*Intermediate Rehabilitation* is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

*Long-Term Habilitation* is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program.

*Group Homes or Halfway Houses* are facilities that provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

c. ***Jail-Based Habilitation Services*** **(531)** offer a substance abuse psychosocial therapeutic community with an expected length of stay of 90 days or more that provides a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Services include intensive daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services. Daily living skills in conjunction with the therapeutic milieu structure are an integral component of the treatment program. Normally, the inmates served by this program are housed separately within the jail.

d. ***Supervised Residential Services*** **(551)** offer **overnight care with supervision and services**. This subcategory includes the following services and Medicaid Mental Retardation HCB Waiver Congregate Residential Support Services.

*Supervised Apartments* are directly-operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals. The expected length of stay normally exceeds 30 days.

*Domiciliary Care* provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility funded or contracted by a CSB.

*Emergency Shelter or Residential Respite* programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

*Sponsored Placements* place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds in the preceding core service subcategories.

e. ***Supportive Residential Services* (581)** are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. This subcategory includes the following services and Medicaid Mental Retardation HCB Waiver Supported Living/In-Home Supports, Respite (Agency and Consumer-Directed) Services, Companion Services (Agency and Consumer-Directed), and Personal Assistance Services (Agency and Consumer-Directed).

*In-Home Respite* provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

*Supported Living Arrangements* are residential alternatives that are not included in other types of residential services. These alternatives assist people to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, PATH grant outreach and support services, and non-CSB subsidized apartments (e.g., HUD certificates).

*Housing Subsidies* provide cash payments only, with no services or staff support, to enable consumers to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for consumers. This is used only for specific allocations of funds from the Department that are earmarked for housing subsidies. Numbers of consumers and expense information should be included in supportive residential services in the contract and reports. Information associated with other housing subsidies should be included in the services of which they are a part.

f. ***Family Support* (587)** offers assistance for families who choose to provide care at home for family members with mental disabilities. Family support is a combination of financial assistance, services, and technical supports that allows families to have control over their lives and the lives of their family members. Family is defined as the natural, adoptive, or foster care family with whom the person with a mental disability resides. Family can also mean an adult relative (i.e., sister, brother, son, daughter, aunt, uncle, cousin, or grand-parent) or interested person who has been appointed full or limited guardian and with whom the person with the mental disability resides. The family defines the support. While it will be different for each family, the support should be flexible and individualized to meet the unique needs of the family and the person with the mental disability. Family support services may include respite care, adaptive equipment, personal care supplies and equipment, behavior management, minor home adaptation or modification, day care, and other extraordinary needs. Family Support also includes Medicaid Mental Retardation Home and Community-Based Waiver Environmental Modifications and Assistive

Technology Services. Units of service are not projected or reported for this subcategory. The identified consumer is the family member with a mental disability. Other family members may be counted as others persons served.

6. **Prevention and Early Intervention Services (600)** are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance abuse, including enhancing the development of handicapped or at-risk infants and toddlers.

   a. ***Prevention Services*** **(610)** involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and alcohol and other drug dependence and abuse. Emphasis is on enhancement of protective factors and reduction of risk factors. The following activities comprise prevention services. Information about these activities will be collected and reported separately from the performance contract. Only units of services and expenses at the subcategory level (Prevention Services) and amounts of funds expended for each activity will be projected and reported through the performance contract process.

   *Information Dissemination* provides awareness and knowledge of the nature and extent of mental illness, mental retardation, developmental disabilities, and alcohol and other drug dependence and abuse. It also provides awareness and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

   *Prevention Education* aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is characterized by two-way communication with close interaction between the facilitator or educator and the program participants. Examples of prevention education include children of alcoholics (COA) groups and parenting classes.

   *Alternatives* provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development; community service projects; alcohol, tobacco, and other drug (ATOD) free activities; and youth centers.

   *Problem Identification and Referral* aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. Examples include student and employee assistance programs.

   *Community-based Process* aims at enhancing the ability of the community to more effectively provide prevention and treatment services. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.

   *Environmental* prevention activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living

conditions. Examples include modifying advertising practices and promoting the establishment and review of ATOD use policies.

b. ***Early Intervention Services*** **(620)** are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. These services apply to all three program areas, mental health, mental retardation, and substance abuse. Early intervention services are generally targeted to identified individuals or groups. Examples of early intervention services include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.

Early Intervention also includes *Infant and Toddler Intervention*, which provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services also prevent or minimize the potential of developmental delays and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and Toddler Intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. It may include audiology, family training, counseling and home visits, health, medical, nursing, nutrition, occupational therapy, physical therapy, psychological, special instruction, speech-language pathology, vision, and transportation services. The identified consumer is the infant or toddler. Family members may be counted as others persons served.

### Additional Community Consumer Submission (CCS) Codes (900 series)

Since tracking of special project and purchase of individualized services initiatives has been discontinued and the component services of those initiatives are being included in the appropriate core services (e.g., outpatient, case management, and various day support and residential services), the numbers of consumers in these initiatives will be counted in the CCS in the following manner.

When a consumer is enrolled in any of the following initiatives, the service code for the initiative will be entered in the enrollment record:

910 - Discharge Assistance Project (DAP)
915 - Non-CSA Mandated Mental Health Child and Adolescent Services
918 - Program of Assertive Community Treatment (PACT)
920 - Medicaid Mental Retardation Home and Community-Based Waiver Services
930 - Substance Abuse State Facility Admission Diversion Project

Units of service for these initiatives will be recorded and accumulated in the applicable core services associated with the initiative (e.g., outpatient, case management, day treatment, rehabilitation, various residential services), but the services may or may not be differentiated or tracked separately for these initiatives, depending on a CSB's information system structure.

***Program of Assertive Community Treatment*** **(918)** is provided by a self-contained, interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full- or part-time psychiatrist that (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; (2) minimally refers individuals to outside service providers; (3) provides services on a long-term care basis with continuity of caregivers over time; (4) delivers 75 percent or more of the services outside of program offices; and (5) emphasizes outreach, relationship building, and individualization of services.

Individuals served by a Program of Assertive Community Treatment (PACT) have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. This also could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of mental retardation. PACT provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. PACT may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills. [This historical definition is included for reference purposes only. The first part of the definition is consistent with the definition in the Department's licensing regulations.]

# Revised Core Services Taxonomy 6

## Core Services Category/Subcategory Matrix

| Services | MH | MR | SA | Unit of Service | Static Capacity |
|---|---|---|---|---|---|
| 1. **Emergency Services** | x | x | x | Service Hour | NA |
| 2. **Inpatient Services** | | | | | |
| a. Medical/Surgical Care | x | x | | Bed Day | Bed |
| b. Skilled Nursing Services | x | x | | Bed Day | Bed |
| c. ICF/MR Services (State Training Center) | | x | | Bed Day | Bed |
| d. ICF/Geriatric Services | x | x | | Bed Day | Bed |
| e. Acute Psychiatric or Substance Abuse Inpatient Services | x | | x | Bed Day | Bed |
| f. Community-Based Substance Abuse Medical Detoxification Inpatient Services | | | x | Bed Day | Bed |
| g. Extended Rehabilitation Services | x | | | Bed Day | Bed |
| 3. **Outpatient and Case Management Services** | | | | | |
| a. Outpatient Services | x | x | x | Service Hour | NA |
| b. Intensive In-home Services | x | | | Service Hour | NA |
| c. Motivational Treatment Services | | | x | Service Hour | NA |
| d. Methadone Detoxification Services | | | x | Service Hour | NA |
| e. Opioid Replacement Therapy Services | | | x | Service Hour | NA |
| f. Case Management Services | x | x | x | Service Hour | NA |
| g. Intensive Community Treatment | x | | | Service Hour | NA |
| h. Consumer Monitoring Services | x | x | x | Service Hour | NA |
| 4. **Day Support Services** | | | | | |
| a. Day Treatment/Partial Hospitalization | x | | x | Day Support Hour | Slot |
| b. Therapeutic Day Treatment for C&A | x | | | Day Support Hour | Slot |
| c. Rehabilitation | x | x | x | Day Support Hour | Slot |
| d. Sheltered Employment | x | x | x | Day of Service | Slot |
| e. Supported Employment-Group Model | x | x | x | Day of Service | Slot |
| f. Transitional or Supported Employment | x | x | x | Service Hour | NA |
| g. Alternative Day Support Arrangements | x | x | x | Service Hour | NA |
| 5. **Residential Services** | | | | | |
| a. Highly Intensive Residential Services | x | x | x | Bed Day | Bed |
| b. Intensive Residential Services | x | x | x | Bed Day | Bed |
| c. Jail-Based Habilitation Services | | | x | Bed Day | Bed |
| d. Supervised Residential Services | x | x | x | Bed Day | Bed |
| e. Supportive Residential Services | x | x | x | Service Hour | NA |
| f. Family Support | x | x | x | NA | NA |
| 6. **Prevention and Early Intervention Services** | | | | | |
| a. Prevention Services | x | x | x | Service Hour | NA |
| b. Early Intervention Services | x | x | x | Service Hour | NA |

# Revised Core Services Taxonomy 6

## Core Services Definitions: Levels of Services

There are two levels of services in this core services taxonomy: contract and actual. The ***contract level*** of services is the number of units of service that the CSB expects to deliver during the contract period. Contract levels are projected in the community services performance contract for all core services categories and subcategories except Family Support. The ***actual level*** of services is the number of units of service actually delivered during the contract period. Actual levels are reported for all core services categories and subcategories in performance contract reports except Family Support.

## Core Services Definitions: Units of Service

There are four kinds of service units in this core services taxonomy: service hours, bed days, day support hours, and days of service. These units are related to different kinds of core services and are used to measure, project, and report delivery of those services.

1. ***Service Hours***

   A service hour is a continuous period measured in fractions or multiples of an hour during which a consumer or group participates in or benefits from the receipt of services. There are two types of service hours: provider service hours and consumer service hours. Only provider service hours are collected though the CCS and shown in the performance contract and reports. Consumer service hours could be collected, used, and reported locally, if desired.

   a. **Provider service hours** measure the amount of staff effort related to the provision of services and are used to calculate unit costs. Provider service hours are hours that are available from all staff providing **direct and consumer-related services** to consumers. For staff with multiple responsibilities, such as program managers who provide some consumer services, include only the portion of time actually available for those services. For example, if a mental health director serves consumers during 20 percent of the work week, that time should be included in provider service hour calculations.

      Since the unit of service is an hour, fractional units should be rounded upward to the nearest quarter hour and quarter hours should be aggregated to whole hours. Unit costs should be calculated based on the total contract or actual service hours, the sum of the direct and consumer-related provider service hours. For some services, such as outpatient services, a direct service unit cost may be calculated using only the direct provider service hours.

      **The following discussion is included only for information purposes, since only total provider service hours (direct and consumer-related) are projected or reported.** Contract and actual provider service hours are calculated based on the following table. CSBs may calculate consumer-related provider service hours for performance contract purposes (to accurately project the total provider service hours) based on historical patterns of actual service delivery or by using subcategory-specific formulas developed by the Department and the Virginia Association of Community Services Boards (VACSB). Indirect services are included in the table only for use in calculating the contract level of provider service hours.

      There are three classifications of activities and services for provider service hours: direct services, consumer-related services, and indirect services. The VACSB Administration Committee and the Department developed the following descriptions.

# Revised Core Services Taxonomy 6

**Direct Services** are activities that occur with the consumer or consumer group present, face-to-face or directly involved. For prevention services only, this includes services provided to individuals, families, groups, and agencies.

**Consumer-Related Services** are services that can be directly attributed to a specific consumer or consumer group, including report writing associated with direct services such as evaluation of a consumer. For prevention services only, this includes activities such as planning and preparation associated with direct services to individuals, families, groups, or agencies.

**Indirect Services** are activities of a general nature that are not attributable to a specific consumer or named consumer group. These services normally relate to the administrative activities of the organization.

This following table lists activities by service classification. While not all inclusive, it represents the most common activities and services.

### *Direct Services*

Individual, Group, Family, Marital, and Rape Counseling and Therapy
Psychological Testing
Medication Visit, Physician Visit
Social Security Disability Evaluation
Intake, Psychiatric, Forensic, Court, and Jail Evaluations
Crisis Intervention
Preadmission Screening
Predischarge Planning, Consumer Present
Emergency Telephone Contacts
Attending Court with Consumer
Case Management, Consumer Present
Individual or Group Consumer Training
Consumer Education
Activity or Recreation Therapy
Skill-Building Group Training
Follow Up and Outreach
Phone Consultation with Consumer
Employee, Student, and Peer Assistance
Peer Self Help or Support
Neighborhood-Based High Risk Youth Programs
Children of Alcoholics Programs
Competency Building Programs
Early Intervention Activities
Infant and Toddler Intervention Activities
Healthy Pregnancies and Fetal Alcohol Syndrome Education
Shaken Baby, Child Abuse and Neglect Prevention and Positive Parenting Programs

### *Consumer-Related Services*

Case-specific Clinical Supervision
Consumer Record Charting
Case Consultation
Treatment Planning Conference
Report Writing Re: Consumer
Consumer-Related Staff Travel
Application for Admission to Facility
Job Development for Consumers
Staff Preparation for Individual, Group, and Family Counseling or Therapy
Pre-Discharge Planning, Consumer not Present
Case Management, Consumer not Present
Coordination of Multi-disciplinary Teams
Consultation to Service Providers
Prevention and Early Intervention Planning and Preparation
Preparing Educational Materials for Prevention and Early Intervention Programs
Preparing for Conferences, Workshops, Training
Staff support to SODA programs

### *Indirect Services*

Facility or Vehicle Maintenance
Administrative Supervision
Committee Participation
Unreported Time
General Staff Travel
Staff and Volunteer Training
Administrative Meetings

b. **Consumer service hours** measure the amounts of services received by individual consumers. Usually, the provider and consumer service hours will be the same except in situations where a provider delivers services to more than one consumer at the same time. For example, if a consumer participates in one hour of individual therapy, the units of service would be one provider service hour and one consumer service hour. However, if the consumer participates in one hour of group therapy with eight other consumers, the units of service would be one provider service hour and nine consumer service hours. Since only provider service hours are shown in the performance contract and reports, **consumer service hours are not projected in the performance contract** and are not reported to the Department. Consumer service hours could be collected, used, and reported locally, if desired. Consumer service hours would not be projected or reported locally for prevention services, since consumers are not identified for prevention services.

2. ***Bed Days***

A bed day involves an overnight stay by a consumer in a residential or inpatient program, facility, or service. Given the unique character of social detoxification, a highly intensive residential service, CSBs may count partial bed days for this service. If a consumer is in a social detoxification program for up to six hours, this would equal ¼ bed day, six to 12 hours would equal ½ bed day, 12 to 18 hours would equal ¾ bed day, and 18 to 24 hours would equal one bed day. Since the unit of service is a bed day, partial bed days should be aggregated to whole bed days in the CCS and performance contracts and reports.

3. ***Day Support Hours***

Many day support services provided to groups of individuals are offered in sessions of two or more consecutive hours. However, Medicaid billing units for State Plan Option and MR Waiver services vary by service. Therefore, counting service units by the smallest reasonable unit, a day support hour, is desirable and useful. Also, Medicaid service units, if different from Taxonomy units of service, need to be converted to Taxonomy units if Medicaid services are included in performance contracts and reports. The day support hour is the unit of service for day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, and rehabilitation. It measures hours received by consumers in those services.

A day support hour is different from a provider service hour (e.g., used to report outpatient services delivered to consumers). Provider service hour units include direct and consumer related activities. These distinctions do not exist for day support hours. This unit allows the collection of more accurate information about services and will facilitate billing various payors that measure service units differently. However, at a minimum, day support programs that deliver services on a group basis must provide at least two consecutive hours in a session to be considered a day support program.

4. ***Days of Service***

Two vocationally-oriented day support services provided to groups of individuals are offered in sessions of three or more consecutive hours. Thus, day of service is the unit of service for Sheltered Employment and Supported Employment-Group Model. A day of service equals five or more hours of service received by a consumer. If a session lasts three or more but less than five hours, it should be counted as a half day. Since the unit of service is a day, fractional units should be aggregated to whole days in performance contracts and reports. Also, Medicaid service units, if different from Taxonomy units of service, need to be converted to Taxonomy units if Medicaid services are included in performance contracts and reports.

***Family Support*** is a unique service modality; it has no unit of service. It has become an increasingly frequent means of providing individualized supports to people with mental disabilities and their families. Because of its unique nature, units of service are not used to measure activity. Instead, the numbers of consumers and families served describe the activity. Further, any other service, such as in-home respite or behavior management, paid with family support funds should be projected and reported as family support instead of the other service subcategory. Additional reporting on amounts expended for adaptive equipment, home modifications, respite services, transportation, and homemaker services and on the number of families helped may be required.

## Core Services Definitions: Static Capacities

1. ***Number of Beds***

   The number of beds is the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the performance contract period.

   If the CSB contracts for bed days without specifying a number of beds, convert the bed days to a static capacity by dividing the bed days by the days in the term of the CSB's contract (e.g., 365 for an annual contract, 183 for a new, half-year contract). If the CSB contracts for the placement of a specified number of individuals, convert this to the number of beds by multiplying the number of consumers by their average length of stay in the program and then dividing the result by the number of days in the CSB's contract period.

2. ***Number of Slots***

   Number of slots means the maximum number of distinct consumers who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed. For example, in psychosocial rehabilitation programs, the number of slots is not the total number of members in the whole program, it is the number of members who can be served at the same time during a session by the program.

   If the CSB contracts for days of service without specifying a number of slots, convert the days of service to a static capacity by dividing the days of service by the days in the term of the CSB's contract (e.g., 248 for an annual contract based on 365 days minus 105 weekend and 12 holiday days). If the CSB contracts for the placement of a specified number of individuals, convert this to days of service by multiplying the number of consumers by the average units of service they receive and then convert the resulting days of service to slots, per the preceding example. If the CSB contracts for day support hours without specifying a number of slots, convert the hours to a static capacity by dividing the day support hours by the number of hours the program is open daily and dividing the result by the number of days the program is open during the CSB's contract period.

## Core Services Definitions: Consumers

Section 37.1-1 of the Code of Virginia defines a consumer as a current or former direct recipient of publicly-funded community or state facility mental health, mental retardation, or substance abuse treatment or habilitation services. For performance contract or report purposes, numbers of consumers will always be the total numbers of individuals who were projected in the performance contract to receive services or who are shown in performance contract reports as actually having received services during the contract period. The Community Consumer Submission (CCS) operationally defines consumers in terms of admission to and discharge from the CSB. Consumers are not counted in prevention programs. Other individuals seen in a program for whom separate consumer records are not opened could be counted and reported separately locally as **other persons served**, but counting and reporting other persons served is not required or possible in the performance contract and reports.

## Revised Core Services Taxonomy 6

## State Facility Cost Accounting System Cost Centers and Codes

| | | | | |
|---|---|---|---|---|
| 2. | a. | **Medical/Surgical** | **410** | |
| | | 1.) Acute Medical/Surgical (Certified) | | 411 |
| | | 2.) Detoxification (Certified) | | 412 |
| | b. | **Skilled Nursing** | **420** | |
| | | 1.) Skilled Nursing-MR (Certified) | | 421 |
| | | 2.) Special/Convalescent Care | | 422 |
| | | 3.) Skilled Nursing-General (Certified) | | 423 |
| | c. | **Intermediate Care Facility/Mentally Retarded** | | |
| | | 1.) ICF/MR (Certified) - Summary | **510** | |
| | | a.) Child Development Services | | 511 |
| | | b.) Educational Development Services | | 512 |
| | | c.) Multi-Handicapped Habilitation Services | | 513 |
| | | d.) Adult Training Services | | 514 |
| | | e.) Community Adjustment Services | | 515 |
| | | f.) Physical Habilitation Services | | 516 |
| | | g.) Social Skills Service | | 517 |
| | | h.) Maladaptive Behavior Services | | 518 |
| | | i.) Extended Care/Health Services | | 519 |
| | | j.) ICF/MR Certified (General) | | 529 |
| | | 2.) ICF/MR (Non-Certified) - Summary | **530** | |
| | | a.) Health Services - Emergency Care | | 531 |
| | | b.) ICF/MR Non-Certified (General) | | 539 |
| | d. | **Intermediate Care Facility/Geriatric** | **440** | |
| | | 1.) ICF (Certified) | | 441 |
| | | 2.) Chronic Disease (Certified) | | 443 |
| | e. | **Acute Intensive Psychiatric** | **455** | |
| | | 1.) Acute Admissions Summary | | 456 |
| | | a.) Certified | | 457 |
| | | b.) Non-Certified | | 458 |
| | | 2.) Intermediate Intensive Treatment | | 461 |
| | | 3.) Geriatric Admissions | | 462 |
| | | 4.) Substance Abuse | | 463 |
| | g. | **Extended Rehabilitation** | **480** | |
| | | 1.) Community Preparation/Psychosocial | | 481 |
| | | 2.) Long Term Rehabilitation | | 482 |
| | | 3.) Behavioral Development/Life Skills | | 483 |
| | | 4.) Child and Adolescent Summary | | 484 |
| | | a.) Child Services | | 485 |
| | | b.) Adolescent Services | | 486 |
| | | c.) Child and Adolescent Services (General) | | 487 |
| | | 5.) Clinical Evaluation | | 488 |
| | | 6.) Forensic, Minimum Security | | 490 |
| | | 7.) Forensic, Maximum Security | | 491 |
| | | 8.) Deaf | | 492 |
| | | 9.) Forensic, Intermediate Security | | 493 |

# Revised Core Services Taxonomy 6

## Performance Contract Definitions

**Access** means the availability of appropriate services to people who need them in a manner that facilitates their use.

**Active Case** means a case in which a consumer who has been admitted for an episode of care is not yet discharged and has received any face-to-face service within the last 90 days.

**Administrative and Management Expenses** means the expenses incurred by the CSB for its administrative functions and for the administrative and management support of services that it provides. These expenses may include, but are not limited to: financial management, accounting, reimbursement, procurement, human resources management, information technology services, clerical support, clinical or service management and supervision, policy development, strategic planning, resource development and acquisition, quality improvement and risk management, facility and transportation management and maintenance, intergovernmental relations, Board member support, and media relations. These functions may be centralized or included in programs and services, depending on the CSB's organization and structure.

**Admission** means the process by which a CSB accepts a person for assessment to determine need for services. Admission is to the CSB, not to a specific program. All persons seen face-to-face for an assessment are admitted to a CSB and a medical record is opened. Consumers who will be receiving services through a CSB-contracted program are admitted to a CSB, based upon a face-to-face clinical assessment. In order for a person to be admitted to a CSB, the following actions are necessary:

- an initial face-to-face contact is made,
- a clinical screening or initial assessment is conducted, and
- a unique consumer identifier is assigned or retrieved from the management information system if the person has been admitted for a previous episode of care.

Admission to a CSB and the date of program enrollment may be the same for a consumer's first program enrollment. It is also possible that an individual's admission to and discharge from a CSB may occur on the same day if there is only a single encounter. The consumer is admitted to a CSB but documentation necessary for enrollment in services is not required when the consumer is seen for only:

- a court-ordered or psychological evaluation,
- an initial assessment (i.e., a single contact for the purpose of screening, triage, and referral), including a preadmission screening assessment that does not result in hospitalization, or
- an initial assessment that results in placement on a waiting list for services with no services provided in the interim.

In these cases, services are provided and numbers served are still counted and reported under the appropriate services category or subcategory (e.g., emergency or outpatient services), but documentation necessary for program enrollment is not required. In these situations, a CSB shall obtain and maintain only the following information on such consumers: unique consumer identifier, date of birth, race, ethnicity, and gender.

Individuals who are seen only for a court-ordered or psychological evaluation or an initial assessment (i.e., a single contact for the purpose of screening, triage, and referral), including a preadmission screening assessment that does not result in hospitalization, and persons who only receive emergency or crisis intervention services or prevention services will not be assessed for priority population membership. Individuals who are seen only for an initial assessment that results in placement on a waiting list for services with no services provided in the interim will be assessed for priority population membership.

In the case of a preadmission screening that results in a state or local hospitalization, the person is admitted to a CSB and enrolled in case management for the purpose of monitoring the individual's hospitalization, predischarge planning, and discharge. Documentation requirements necessary for enrollment, however, are waived until the individual is discharged from the hospital and returns to the CSB for services, if that is the disposition.

**Case Management CSB** means the CSB that serves the area in which the consumer resides. The case management CSB is responsible for case management, liaison with the state facility when a person is admitted to a state psychiatric facility or training center, and predischarge planning. Any change in case management CSB for a consumer shall be implemented in accordance with the current *Discharge Planning Protocols* to ensure a smooth transition for the consumer and the CSB. Case management CSB also means the CSB to which bed day utilization is assigned, beginning on the day of admission, for an episode of care and treatment when a consumer is admitted to a state facility.

**Closed Case** means a case in which a consumer has been discharged from an episode of care.

**Consumer** means a current direct recipient of publicly-funded community or state facility mental health, mental retardation, or substance abuse treatment or habilitation services.

**Consumer Outcome Measures** means indicators that describe at the consumer level what the individual is able to achieve, based on his goals and abilities, with the support and assistance that he receives from the provider. These indicators can be used to gauge the effectiveness of services for a specific condition and the results of episodes of care.

**Discharge** means the process by which a CSB releases a person from an episode of care, thereby closing the consumer's medical record. Discharge occurs at the CSB level, as opposed to release from a specific service or program. A person is discharged from a CSB if any of the following conditions exists. The consumer has:

- been determined to need no further services,
- been released from enrollment at all CSB and CSB-contracted services and discharged in accordance with CSB policies,
- received no CSB services in 180 days from the date of the last face-to-face contact or has indicated that he no longer desires to receive services, or
- relocated or died.

Persons may be discharged in less than the maximum time since the last face-to-face contact (i.e., less than 180 days) at the CSB's discretion, but the person must be discharged if no face-to-face services have been received in the maximum allowable time period for that episode of care. Once discharged, should a consumer return for services, that person must be readmitted; the subsequent admission would begin a new episode of care.

**Enrollment** means the process by which a CSB or CSB-contracted program accepts a person into a program for services for an identified condition or, for persons with mental retardation, an identified support need. Enrollment implies an intention for the consumer to receive ongoing services under the direction of the consumer's individualized services plan or plan of care. In order for a program enrollment to occur, the following actions, accompanied by appropriate documentation, are necessary:

- determination that the person is in need of services available through the CSB or its contracted agencies,
- completion of a psychosocial history (if not fully completed at the time of admission),
- diagnosis or provisional diagnosis of the consumer's condition,
- determination of priority population classification status, and
- initiation of the development of an individualized services plan.

**Episode of Care** includes all of the services provided to a consumer to address an identified condition or support need over a continuous period of time between an admission and a discharge. An episode of care may consist of a single face-to-face encounter or multiple services provided through one or more programs.

**Inactive Case** means a case that does not meet the criteria for an active case, but has not yet been closed (i.e., the person has not been discharged). When a person returns for services prior to discharge, the person's case is returned to an active status, and the CSB does not readmit the consumer. That is, services provided within the 180-day period are considered to be part of the same episode of care until the time of that consumer's discharge. This definition does not apply to individuals receiving respite services (supervised or supportive residential services) or summer camp services (alternative day support services).

**Mental Retardation**, as defined by the *Code of Virginia*, means substantial sub-average general intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior.

The American Association on Mental Retardation definition, provided here for additional clarity, refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations (the limitations in adaptive skills are more closely related to the intellectual limitation than to some other circumstances such as cultural or linguistic diversity or sensory limitation) in two of more of the following applicable adaptive skills areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports. Mental retardation manifests before age 18. A diagnosis of mental retardation is made independent of related mental disorders (e.g., autistic disorder and learning disorders) and general medical conditions (e.g., epilepsy and cerebral palsy). Intellectual functioning alone may be insufficient to diagnose mental retardation. Limitations in adaptive skills areas are also typically present.

**Priority Populations** means those groups of individuals who have the most serious or severe disabilities, in terms of diagnosis, functional criteria, and the presence of multiple disabilities. Specific criteria for each priority population are appended to the Core Services Taxonomy in Appendix A.

**Mental Health Priority Populations** are:

- ***adults***, assessed along three dimensions: diagnosis, functional impairment, and duration;
- ***children*** (birth through age 17), assessed on two dimensions: diagnosis and functional impairment; and
- ***at risk children*** (birth through age 17).

**Mental Retardation Priority Populations** are:

- ***mental retardation:*** adults and children three years of age or older who have a confirmed diagnosis of mental retardation;
- ***cognitive delay:*** children three to six years of age who have a confirmation of cognitive developmental delay within one year of the priority populations assessment; and
- ***early intervention***: children under three years of age with confirmed eligibility for Part C of IDEA.

**Substance Abuse Priority Populations** are:

- ***substance dependence:*** individuals with a substance dependence (addiction) diagnosis, as defined by the Diagnostic and Statistical Manual IV (DSM IV), and use in the past 12 months (use is not required if the person has been incarcerated for 12 months or more and seeks treatment within 60 days of release);
- ***substance abuse in a target population:*** individuals with a substance abuse diagnosis, as defined by the DSM IV, and use in the past 12 months if the person is a child or adolescent (less than 18 years old), pregnant, a woman who has legal custody of and lives with dependent children (under the age of 18), or belongs to the adult mental health priority population; and
- ***substance-related violence:*** individuals who have exhibited violent behavior in the past 12 months related to substance use that resulted in intervention by the mental health or judicial system. These behaviors include: damaging or destroying property, physical assault, threats of physical violence, and self-injury. Driving under the influence or driving while intoxicated arrests do not meet the definition of violence.

**Program Area** means the general classification of service activity for a defined population. There are three program areas in the public services system: mental health, mental retardation, and substance abuse.

**Provider Performance Measures** means the indicators that describe at the program area level what the provider was able to achieve, based on pre-established goals and objectives.

**Quality Improvement** means continuously planning, measuring, and assessing performance to improve services, processes, and consumer outcomes.

**Release** means the process by which a CSB or CSB-contracted program documents that a consumer has completed receiving services from a particular program in which he was enrolled. When this occurs, the consumer is **released** or dis-enrolled from that program. When that consumer has completed receiving all services in all programs in which he was enrolled, he has completed the current episode of care and is discharged from the CSB.

**Service Area** means the geographic area (city and county names) that a CSB serves.

**Subcontract** means a written agreement between a CSB and a third party, under which the third party performs any of the CSB's obligations. Subcontracts, unless the context or situation supports a different interpretation or meaning, also may include agreements, memoranda of understanding, purchase orders, contracts, or other similar documents for the purchase by a CSB of services or goods from another organization or agency or a person on behalf of an individual consumer.

**Subcontractor** means an entity that agrees to furnish services to consumers or to perform any administrative function or service for a CSB specifically related to fulfilling the CSB’s obligations.

**Substance Abuse**, as defined by DSM IV, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

3. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxification, physical fights).

The symptoms have never met the criteria for substance addiction (dependence).

**Substance Addiction (Dependence)** means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. DSM IV defines substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by a need for markedly increased amounts of the substance to achieve intoxification or desired effect or markedly diminished effect with continued use of the same amount of the substance;
2. withdrawal, as manifested by the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
3. the substance is often taken in larger amounts or over a longer period than was intended;
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. a great deal of time is spent on activities necessary to obtain the substance, use the substance, or recover from its effects;
6. important social, occupational, or recreational activities are given up or reduced because of substance use; and
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

# Revised Core Services Taxonomy 6

## Appendix A: Adult Mental Health Priority Population Criteria

These criteria define the Adult Mental Health Priority Population. ***An adult is a person who is 18 years old or older.*** Inclusion in a priority population is not a prerequisite for receiving services.

**1. Diagnosis:** Does the person have one of the following diagnoses? (If yes, check the diagnosis.)

__ Schizophrenia, all types (295.10, 295.20, 295.30, 295.60, 295.90)
__ Schizophreniform Disorder (295.40)
__ Schizoaffective Disorder (295.70)
__ Psychotic Disorder, NOS (298.9x)

***If any diagnosis is checked, the person is in the Adult Mental Health Priority Population.*** The qualifying diagnosis must be in the person's clinical record and the CSB's information system.

If no diagnosis is checked, go to Mood and Anxiety Disorders With Other Criteria below.

**2. Mood and Anxiety Disorders With Other Criteria**

A. **Diagnosis:** Does the person have one of the following diagnoses? (If yes, check the diagnosis.)

__ Bipolar I Disorder (296.0x, 296.40, 296.4x, 296.6x, 296.5x, 296.7)
__ Bipolar II Disorder (296.89)
__ Bipolar Disorder, NOS (296.80)
__ Major Depressive Disorder (296.2x, 296.3x)
__ Panic Disorder with or without Agoraphobia (300.01, 300.21)
__ Obsessive-Compulsive Disorder (300.3) **And**

B. **Other Criteria:** Does the person meet one or more of the following? (Check all that apply)

__ Has psychotic symptoms (hallucinations and delusions) or takes medication to control them.
__ Has had a public or private psychiatric hospitalization in the past 12 months.
__ Has attempted suicide or had a specific plan for committing suicide in the past 12 months.

***If any diagnosis in A is checked and at least one Other Criteria in B is checked, the person is in the Adult Mental Health Priority Population.*** The qualifying diagnosis and other criteria must be documented in the person's clinical record, and the qualifying diagnosis must be in the CSB's information system.

If one item in A and at least one in B are not checked, go to Diagnosis and Functional Impairment.

**3. Diagnosis and Functional Impairment**

A. **Diagnosis**: Does the person have either an:

__ Axis I Mental Disorder **other than** Adjustment Disorder, "V" Codes, Substance Abuse, Impulse Control Disorder, or Organic Disorder (e.g., Delirium, Dementia, Substance-Induced Disorder), **OR**
__ Axis II Personality Disorder **AND** has had two or more episodes of decompensated functioning over the past 12 months that have required mental health services.

If neither is checked, go to Duration of Illness and History of Impairment on the next page. If either is checked, proceed to document the person's functional impairment in B. The qualifying diagnosis must be in the person's clinical record and the CSB's information system.

**B. Functional Impairment:** Check all criteria that apply presently or within the past 12 months. Written documentation in the person's clinical record must support that the criterion is met as a direct result or manifestation of the person's mental illness.

__ **Employment:** The person is unable to hold a job or is only able to work part time for reasons that are specifically related to his or her mental illness (i.e., reasons do not involve being a student or parent or having a physical disability), OR is employed in a supported or sheltered setting OR requires a special learning environment in order to remain in school.

__ **Social Isolation:** The person is not in a supportive, confiding relationship with anyone in his or her life (excluding professionals) and has face-to-face interactions with friends or family members no more than once per month on average.

__ **Inappropriate or Dangerous Behavior:** The person's behavior results in intervention by the mental health or judicial system. The person damages or destroys property, is physically assaultive, threatens physical violence, is self-injurious, or creates public disturbances that result in arrest or involuntary admission to an inpatient facility. Abuse of alcohol or drugs alone is not sufficient to meet this criterion.

__ **Homelessness:** The person is homeless or at risk of homelessness (i.e., is highly transient or has experienced one or more episodes of homelessness in the past 12 months or is living in a shared transient setting).

__ **Suicide Risk:** The person has attempted suicide or has had a specific plan for committing suicide at some time in the past 12 months. A history of suicidal ideation alone is not sufficient to meet this criterion.

__ **At Risk of Physical Abuse:** The person is involved in a physically violent relationship that poses a significant risk or danger to the consumer.

***If one of the diagnoses in section A is checked and one or more of the functional criteria above is met, the person is in the Adult Mental Health Priority Population.***

If neither diagnosis is checked **and** none of the functional criteria are met, go to Duration of Illness and History of Impairment below.

**4. Duration of Illness and History of Impairment:** Does the person have

__ a Mood or Anxiety Disorder under criterion 2 **and** a Psychiatric Hospitalization within the past four years **and** relapse is likely to occur without continuing treatment, **OR**

__ a Mental Health Diagnosis **and** a documented history of Severe Functional Impairment, excluding a risk of physical abuse, such that he or she has met the functional criteria under criterion 3 within the past four years **and** relapse is likely to occur without continuing treatment.

***If one of these is checked, the person is in the Adult Mental Health Priority Population.***

If neither is checked, the person is not in the Adult Mental Health Priority Population.

Any diagnosis must be documented in the person's clinical record and the CSB's information system, and the record must also contain documentation that the person meets any other priority population criteria checked.

# Revised Core Services Taxonomy 6

## Appendix A: Child Mental Health Priority Population Criteria

These criteria define the Child Mental Health Priority Population. ***A child is a person who is 17 years old or younger.*** Inclusion in a priority population is not a prerequisite for receiving services.

**1. Diagnosis:** Does the child have one of the following diagnoses? (If yes, check the diagnosis.)

**Psychotic Disorders, Depression, and Bipolar Disorders**

__ Schizophrenia, all types (295.10, 295.20, 295.30, 295.60, 295.90)
__ Schizophreniform Disorder (295.40)
__ Schizoaffective Disorder (295.70)
__ Psychotic Disorder, NOS (298.9x)
__ Bipolar I Disorder (296.0x, 296.40, 296.4x, 296.6x, 296.5x, 296.7)
__ Bipolar II Disorder (296.89)
__ Bipolar Disorder, NOS (296.80)
__ Major Depressive Disorder (296.2x, 296.3x)

***If any diagnosis is checked, the person is in the Child Mental Health Priority Population.***
If none are checked, go to Suicide below.

**2. Suicide:** Has the child attempted suicide in the past year or does the child have a current plan to commit suicide?

__ Yes. ***If checked, the child is in the Child Mental Health Priority Population.***
__ No. If checked, go to Functional Criteria below.

3. **Functional Criteria:** Check all functional criteria that apply in sections A and B below. Written documentation in the child's clinical record must support that the criterion is met as a direct result or manifestation of the child's emotional or behavioral problems.

A. The child has had problems ***in the last 12 months*** that are significantly disabling, based upon the social functioning of most children of the same age as the child. The child has:

__ had a specific plan for committing suicide or has current and persistent suicidal ideation. A history of suicidal ideation alone is not sufficient to meet this criterion.
__ exhibited recurrent and non-accidental self-injurious behavior.
__ been hospitalized in a public or private psychiatric facility.
__ been enrolled with an IEP in a special education program for children with emotional disturbance or is scheduled for an IEP to determine placement in a special education program for children with emotional disturbance.
__ routinely missed two or more days of school or work per month as a direct result of symptoms associated with his or her mental illness. Do not include absences due to physical illness.
__ experienced a drop in school performance or productivity to the point that there is a risk of failing at least half of his or her courses.
__ exhibited behavior that presents a danger to the safety of others as a result of persistent homicidal ideation or threats or disruptive or aggressive behavior.
__ persistent problems or difficulties in relating to peers that result in few, if any, positive peer relationships.
__ at least one family relationship characterized by chronic conflict that is disruptive to the family environment.
__ required intervention by at least one agency other than the CSB.

B. The child has or will have problems in personality development and social functioning ***over at least one year's time***.

__ problems have lasted for at least one year.
__ problems are expected to last at least one year without services.

Does the child meet ***at least two*** functional criteria in section A **AND *at least one*** criterion in section B?

__ Yes. ***If checked, the child is in the Child Mental Health Priority Population.***
__ No. If checked, the child is not in the Child Mental Health Priority Population. Proceed to the At Risk Child Mental Health Priority Population Criteria below.

Any diagnosis must be documented in the person's clinical record and the Board's information system, and the record must also contain documentation that the person meets any other priority population criteria checked.

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## Appendix A: At Risk Child Mental Health Priority Population Criteria

These criteria define the At Risk Child Mental Health Priority Population. ***These criteria should be used only if a child does not meet the Child Mental Health Criteria. A child is a person who is 17 years old or younger.*** Inclusion in a priority population is not a prerequisite for receiving services.

It is Departmental policy that children through age 17 may be considered at risk for developing serious emotional disturbance, if they are exposed to significant risk factors. This does not represent a change in Medicaid eligibility or reimbursement policies for targeted case management, where the age range is 0 through 7 years for at risk children and 0 through 17 for children who meet the criteria for serious emotional disturbance.

**Does the child meet any one of the following criteria?** (Check all criteria that apply.)

__ The child has experienced sexual or physical abuse or severe neglect that is supported by documented evidence in his or her clinical record or other social service agency records. Abuse or neglect does not need to be founded necessarily by the Department of Social Services. A report of abuse that is documented in the clinical record is sufficient to meet this criterion.

__ The child has experienced other physical or psychological stressors, such as chronic and disabling physical illness, that put him or her at risk for developing serious emotional or behavioral problems.

__ The child has parents or caretakers who have predisposing factors that could result in the child developing serious emotional or behavioral problems. Predisposing factors include, but are not limited to, the following: a parent or caretaker has been determined to have a serious mental illness or mental retardation, use alcohol or illegal substances excessively, be homeless, or have another documented factor.

__ The child exhibits behavior or maturity that is significantly different from most children of his or her age and is not the result of a developmental disability or mental retardation.

**Does the child meet the criteria for the At Risk Child Mental Health Priority Population?**

__ Yes. ***If at least one of the criteria above is checked, the child is in the At Risk Child Mental Health Priority Population.*** The clinical record must contain documentation that the person meets any priority population criteria checked.

__ No. If none of the criteria above are checked, the child is not in this Priority Population.

# Revised Core Services Taxonomy 6

## Appendix A: Mental Retardation Priority Populations Criteria

There are three priority populations in the mental retardation program area: mental retardation, cognitive delay, and early intervention (Part C of the IDEA). Inclusion in a priority population is not a prerequisite for receiving services.

**1. Mental Retardation Priority Population Criteria** (Check only one choice, if applicable)

__ The person is an adult (18 years of age or older) and has a confirmed diagnosis of mental retardation (DSM IV).
__ The person is a child who is at least three but less than 18 years old and has a confirmed diagnosis of mental retardation (DSM IV).

***If either criterion is checked, the person is in the Mental Retardation Priority Population.***

If neither criterion is checked, the person is not in this priority population.

Documentation of a diagnosis of mental retardation must be from an appropriate professional who is licensed by the State of Virginia to perform diagnostic testing and has conducted standardized assessments of intellectual functioning and adaptive behavior skills. Section 37.1-1 of the *Code of Virginia* defines mental retardation as substantial sub-average general intellectual functioning that originates during the development period and is associated with impairment in adaptive behavior.

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Section 19.2-264.3:1.1 of the *Code of Virginia* defines mental retardation more extensively. ***This language is included for reference purposes only. Obviously, references to defendants and corrections records are not applicable. However, this definition contains more detailed and helpful information than the definition in § 37.1-1.*** Mental retardation means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly sub-average intellectual functioning, as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. Assessments of mental retardation under this section conform to the following requirements.

1. Assessment of intellectual functioning shall include administration of at least one standardized measure generally accepted by the field of psychological testing and appropriate for administration to the particular defendant being assessed, taking into account cultural, linguistic, sensory, motor, behavioral, and other individual factors. Testing of intellectual functioning shall be carried out in conformity with accepted professional practice, and, whenever indicated, the assessment shall include information from multiple sources.
2. Assessment of adaptive behavior shall be based on multiple sources of information, including clinical interviews, psychological testing, and educational, correctional, and vocational records. The assessment shall include at least one standardized measure generally accepted by the field of psychological testing for assessing adaptive behavior and appropriate for administration to the particular defendant being assessed, unless not feasible. In reaching a clinical judgment regarding whether the defendant exhibits significant limitations in adaptive behavior, the examiner shall give performance on standardized measures whatever weight is clinically appropriate in light of the defendant's history and characteristics and the context of the assessment.

3. Assessment of developmental origin shall be based on multiple sources of information generally accepted by the field of psychological testing and appropriate for the particular defendant being assessed, including, whenever available, educational, social service, and medical records, prior disability assessments, parental or caregiver reports, and other collateral data, recognizing that valid clinical assessment conducted during the defendant's childhood may not have conformed to current practice standards.

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**2. Cognitive Delay Priority Population Criteria** (Check only if applicable)

__ The person is a child who is at least three but less than six years old and has a confirmed cognitive developmental delay within one year of this assessment.

***If this criterion is checked, the person is in the Cognitive Delay Priority Population.***

If this criterion is not checked, the person is not in this priority population.

Documentation of a confirmed cognitive developmental delay must be from a multidisciplinary team of trained personnel, using a variety of valid assessment instruments. A confirmed delay will be noted on the test with a score that is at least 25 percent below the child's chronological age in one or more areas of cognitive development.

A developmental delay is defined as a significant delay in one of the following developmental areas: cognitive ability, motor skills, social/adaptive behavior, perceptual skills, or communication skills. A multidisciplinary team of trained personnel will measure developmental delay (25 percent below the child's chronological age) by a using a variety of valid assessment instruments. The most frequently used instruments in Virginia's local school systems are the Battelle Developmental Inventory, Learning Accomplishments Profile – Diagnostic Edition (LAP-D), the Early Learning Accomplishment Profile (ELAP), and the Hawaiian Early Learning Profile (HELP). For infants and toddlers born prematurely (gestation period of less than 37 weeks), the child's actual adjusted age is used to determine his or her developmental status. Chronological age is used once the child is 18 months old.

**3. Early Intervention Priority Population Criteria** (Check only if applicable)

__ The person is a child who is under three years old and has a confirmed eligibility for Part C of the Individuals with Disabilities Education Act (IDEA).

***If this criterion is checked, the person is in the Early Intervention Priority Population.***

If this criterion is not checked, the person is not in this priority population.

For any priority population, any diagnosis must be documented in the person's service record and the CSB's information system, and the record must also contain documentation that the person meets any other priority population criteria checked.

# Appendix A: Substance Abuse Priority Populations Criteria

There are three priority populations in the substance abuse program area: substance dependence, substance abuse, and substance-related violence. Inclusion in a priority population is not a prerequisite for receiving services.

**1. Substance Dependence Priority Population Criteria**

__ The person has a **substance dependence** diagnosis (DSM IV) and has used substances within the past 12 months. Use is not required if the person has been incarcerated for 12 months or more and seeks treatment within 60 days of release.

***If this criterion is checked, the person is in the Substance Dependence Priority Population.***

If this criterion is not checked, the person is not in the Substance Dependence Priority Population; go to the Substance Abuse Priority Population Criteria below.

**2. Substance Abuse Priority Population Criteria**

A. The person is: (Check all that apply)
__ a child (under 18 years old),
__ pregnant,
__ a woman who has legal custody of and lives with a dependent child (under 18 years old), or
__ in the Adult Mental Health Priority Population.

B. Does the person have a **substance abuse** diagnosis (DSM IV)?

__ Yes. ***If checked and if at least one item in A is checked, the person is in the Substance Abuse Priority Population.***

__ No. If checked, the person is not in the Substance Abuse Priority Population; go to the Substance-Related Violence Priority Population Criteria.

**3. Substance-Related Violence Priority Population Criteria**

Has the person exhibited violent behavior related to substance use in the past 12 months that resulted in an intervention by the mental health or judicial system? Examples of violent behavior include: damaging or destroying property, physical assault, threats of physical violence, and self-injury. Driving under the influence or driving while intoxicated arrests do not meet the definition of violence.

__ Yes. ***If checked, the person is in the Substance-Related Violence Priority Population.***
__ No. If checked, the person is not in the Substance-Related Violence Priority Population.

Any substance dependence or abuse diagnosis must be documented in the person's clinical record and the CSB's information system, and the record must also contain documentation that the person meets any other priority population criteria checked.

# Appendix B: Core Services Taxonomy and Medicaid Mental Retardation Home and Community-Based Waiver Services Crosswalk

| Core Services Taxonomy Service | MR Home and Community-Based Waiver Service |
|---|---|
| Emergency Services | Crisis Stabilization<br>Personal Emergency Response System [1] |
| Inpatient Services | None |
| Outpatient Services | Skilled Nursing Services [2]<br>Therapeutic Consultation [3] |
| Case Management Services | None. Case Management is not a Waiver service. |
| Day Health and Habilitation | Day Support (Center-Based and Non-Center-Based)<br>Prevocational |
| Day Support: Sheltered Employment | None |
| Supported Employment- Group Model | Supported Employment – Group Model |
| Transitional or Supported Employment | Supported Employment - Individual Placement |
| Alternative Day Support Arrangements | None |
| Highly Intensive Residential Services | None, this is ICF/MR services in the Taxonomy. |
| Intensive Residential Services | Congregate Residential Support Services [7] |
| Supervised Residential Services | Congregate Residential Support Services [7] |
| Supportive Residential Services | Supported Living/In-Home Residential Supports<br>Respite Services (Agency and Consumer-Directed)<br>Personal Assistance Services (Agency and Consumer-Directed) [4]<br>Companion Services (Agency and Consumer-Directed) |
| Family Support | Environmental Modifications [5]<br>Assistive Technology [6] |
| Early Intervention | None |

This Crosswalk is included in the Taxonomy for information purposes. Where there is an inconsistency between Medicaid service units and Taxonomy units of service, Taxonomy units of service will be used for Performance Contract, Uniform Cost Report, and Community Consumer Submission purposes. Efforts to reduce or eliminate inconsistencies will be made in the development of Core Services Taxonomy 7, which will replace the current Taxonomy in FY 2006.

[1] **Personal Emergency Response System** will be counted in the Taxonomy and performance contract in terms of numbers of consumers served and expenses; there are no Taxonomy units of service for this Medicaid service.

[2] **Skilled Nursing Services** are available to consumers with serious medical conditions and complex health care needs that require specific skilled nursing services that are long term and maintenance in nature ordered by a physician and ***which cannot be accessed under the Medicaid State Plan***, which offers short-term skilled nursing services (up to 32 visits without preauthorization, with additional visits preauthorized) under Home Health Services. Services are provided in the consumer's home or a community setting on a regularly scheduled or intermittent need basis. The Medicaid service unit is one hour.

[3] **Therapeutic Consultation** provides expertise, training, and technical assistance in a specialty area (psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy, or physical therapy) to assist family members, care givers, and other service providers in supporting the consumer. MR Waiver therapeutic consultation services may not include direct therapy provided to Waiver consumers, nor duplicate the activities of other services that are available to the individual through the Medicaid State Plan. This service may not be billed solely for the purposes of monitoring. The Medicaid service unit is one hour. Therapeutic Consultation is included under Outpatient Services in the Crosswalk, rather than in Case Management Services, to preserve the unique nature of Case Management Services and because it seemed to fit most easily in Outpatient Services. This also is the preference expressed by the MR Council.

[4] **Personal Assistance Services** are available to MR Waiver consumers who do not receive residential support (congregate or supported living/in-home) services and for whom training and skills development are not primary objectives or are received in another service or program. Personal assistance means direct assistance with personal care, activities of daily living, medication or other medical needs, and monitoring physical condition. It may be provided in residential or non-residential settings to enable a consumer to maintain health status and functional skills necessary to live in the community or participate in community activities. Personal assistance services may not be provided during the same hours as Waiver supported employment or day support. Personal assistance services will not be authorized for a consumer who receives residential support (congregate or supported living/in-home) services or lives in an adult care residence/assisted living facility. The Medicaid service unit is one hour. Personal Assistance Services and Companion Services are included under Supportive Residential Services because they are more residentially based than day support based. Also, the credentials for both include Department residential services licenses. This also is the preference expressed by the MR Council. Finally, the Medicaid service unit and the Taxonomy unit of service are the same, a (provider) service hour.

[5] **Environmental Modifications** are available to consumers who are receiving at least one other MR Waiver service along with Medicaid targeted case management services. Modifications are provided as needed only for situations of direct medical or remedial benefit to the consumer. These are provided primarily in a consumer's home or other community residence. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Environmental modifications include physical adaptations to a house or place of residence necessary to ensure a consumer's health or safety or to enable the consumer to live in a non-institutional setting, environmental modifications to a work site that exceed reasonable accommodation requirements of the Americans with Disabilities Act, and modifications to a family vehicle to allow the consumer who requires the use of a wheelchair to safely have access to and travel in the family car or van. The Medicaid service unit is hourly for rehabilitation engineering, individually contracted for building contractors, and may include supplies.

[6] **Assistive Technology** is available to consumers who are receiving at least one other MR Waiver service along with Medicaid targeted case management services. It may be provided in a residential or non-residential setting. The Medicaid service unit is hourly for rehabilitation engineering or the total cost of the item or the supplies.

[7] **Congregate Residential Support Services** have a Medicaid service unit measured in hours; this is inconsistent with the Taxonomy bed day unit of service for Intensive And Supervised Residential Services. Therefore, Congregate Residential Support Services will be counted in the Taxonomy and performance contract in terms of numbers of consumers served and expenses; there are no Taxonomy units of service for these Medicaid services.

# Appendix C: Medicaid Mental Retardation Home and Community-Based Waiver Service Definitions

These condensed Medicaid definitions are appended to the Taxonomy for information and reference purposes only. Complete official definitions can be found in the Mental Retardation Community Services Manual, issued by the Department of Medical Assistance Services (DMAS) and available at www.dmas.state.va.us. DMAS may revise service definitions at any time. Service units in the following definitions are Medicaid units. In some instances, Taxonomy service unit definitions are intentionally not consistent with these Medicaid service unit definitions. In those situations, the Taxonomy service unit usually is smaller and can be aggregated up to the Medicaid service unit.

## Assistive Technology

Assistive Technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the *State Plan for Medical Assistance (SPMA)*, that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. Equipment and activities include:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the *SPMA;*
2. Durable or non-durable medical equipment and supplies (DME) not available under the *SPMA*;
3. Adaptive devices, appliances, and controls not available under the *SPMA* that enable an individual to be more independent in areas of personal care and activities of daily living; and
4. Equipment and devices not available under the *SPMA* that enable an individual to communicate more effectively.

### *Medicaid Service Units and Service Limitations*

The service unit for items and supplies is the total cost of the item and any supplies. The service unit for Rehabilitation Engineering is hourly. The maximum Medicaid funded expenditure for Assistive Technology is $5,000.00 per consumer service plan (CSP) year. The cost for Assistive Technology cannot be carried over from one CSP year to the next and must be preauthorized each CSP year.

## Companion Services (Agency-Directed)

Companion services provide non-medical care, socialization, or support to adults in an individual's home or at various locations in the community. Allowable activities include:

1. Assistance or support with tasks such as meal preparation, laundry and shopping;
2. Assistance with light housekeeping tasks;
3. Assistance with self-administration of medication;
4. Assistance or support with community access and recreational activities; and
5. Support to assure the safety of the individual.

### *Medicaid Service Units and Service Limitations*

Companion services must be billed on an hourly basis. The amount of Companion services time included in the CSP may not exceed eight hours per 24-hour day.

**Companion Services (Consumer-Directed)**

Companion services provide non-medical care, socialization or support to adults in an individual's home or at various locations in the community. Allowable activities are the same as agency-directed Companion Services.

***Medicaid Service Units and Service Limitations***

Companions are paid an hourly rate. The Fiscal Agent pays a companion on behalf of the individual once the timesheet is signed by the companion and the individual and forwarded to the Fiscal Agent. Companion services must be billed on an hourly basis. The amount of Companion services time included in the ISP may not exceed eight hours per 24-hour day.

**Crisis Stabilization Services**

Crisis Stabilization is direct intervention (and may include one-to-one supervision) to persons with mental retardation who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The goal is to provide temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional admission or to prevent other out-of-home placement. The intent is to stabilize the individual and to strengthen the current living situation so the individual can be maintained during and beyond the crisis period. Allowable activities include:

1. Psychiatric, neuropsychiatric, and psychological assessment, and other functional assessments and stabilization techniques;
2. Medication management and monitoring;
3. Behavior assessment and positive behavior support;
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;
5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community; and
6. Temporary Crisis Supervision (as a separate billable service) to ensure the safety of the individual and others.

***Medicaid Service Units and Service Limitations***

Mental Retardation Crisis Stabilization Clinical or Behavioral services are billed in hourly service units and may be authorized for provision during a maximum of 15 days. Service can be provided no more than 60 days in a calendar year. Crisis Supervision, if provided within the authorized period as a component of this service, is separately billed in hourly service units.

**Day Support**

Day Support services include training, assistance or specialized supervision for the acquisition, retention or improvement in self-help, socialization and adaptive skills. It allows peer interactions and an opportunity for community and social integration. Specialized supervision provides staff presence for ongoing or intermittent intervention to ensure an individual's health and safety. These services typically take place in non-residential settings, separate from the home or facility in which the individual resides. Day Support services focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech/language therapies listed in the CSP. In addition, day support services may serve to reinforce skills or lessons taught in school, therapy or other settings. Services are normally furnished one or more hours per day on a regularly scheduled basis for one or more days per week. Allowable services include:

1. Functional training in self, social, and environmental awareness skills;
2. Functional training in sensory stimulation and gross and fine motor skills;
3. Functional training in communication and personal care;
4. Functional training in the use of community resources, community safety, appropriate peer interactions, and social skills;
5. Functional training in learning and problem-solving skills;
6. Functional training in adapting behavior to social and community settings;
7. Assistance with personal care and use of community resources;
8. Supervision to ensure the individual's health and safety;
9. Staff coverage for transportation of the individual between training and service activity sites; and
10. Opportunities to use functional skills in community settings.

***Types and Levels of Day Support***

The amount and type of Day Support included in the individual's CSP is determined according to the level of staff involvement required for that individual. There are two types of Day Support: Center-based, which is provided primarily in a single location with other individuals with disabilities, and Non-center-based, which is provided primarily in community settings. Non-center-based Day Support services must be separate and distinguishable from In-home/Supported Living Residential Support or Personal Assistance services. There must be separate, supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. Both types of Day Support may be provided at Intensive or Regular Levels. To be authorized at the Intensive Level, the individual must meet at least one of the following criteria:

- Requires physical assistance to meet basic personal care needs (toileting, feeding, etc.);
- Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals; or
- Requires extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program.

A written behavioral objective in the ISP is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

***Medicaid Service Units and Service Limitations***

Billing is for a unit of service:

- One unit is 1 to 3.99 hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25 percent of the total time spent in the Day Support activity for that day.
- Two units are 4 to 6.99 hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25 percent of the total time spent in the Day Support activity for that day; and
- Three units are 7 or more hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25 percent of the total time spent in the Day Support activity for that day; however, a minimum of 7 hours of other allowable activities must be provided in order to be reimbursed for a 3-unit day.

The ISP must provide an estimate of the amount of Day Support required by the individual. The maximum is 780 units per consumer service plan (CSP) year.

**Environmental Modifications**

Environmental Modifications are physical adaptations to a person's home or community residence, vehicle, and, in some instances, workplace that provide direct medical or remedial benefit to him or her. These adaptations are necessary to ensure the health, welfare, and safety of the individual or enable the person to function with greater independence in the home or work site. Without these adaptations, the individual would require institutionalization. Modifications and activities are:

1. Physical adaptations to a house or place of residence necessary to ensure an individual's health, welfare, and safety (e.g., installation of specialized electric and plumbing systems to accommodate medical equipment and supplies);
2. Physical adaptations to a house or place of residence that enable an individual to live in a non-institutional setting and to function with greater independence but do not increase the square footage of the house or place of residence (e.g., installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities);
3. Environmental modifications to the work site that exceed reasonable accommodation requirements of the employer under the Americans with Disabilities Act; and
4. Modifications to the primary vehicle being used by the individual.

***Medicaid Service Units and Service Limitations***

The service unit for Rehabilitation Engineering is hourly. Building contractor services are individually contracted for and may include supplies or the total cost of supplies may be billed separately. The maximum Medicaid-funded expenditure for environmental modifications is $5,000.00 per CSP year. Costs for environmental modifications cannot be carried over from one CSP year to the next, and must be pre-authorized each CSP year. Environmental modifications may not be used to bring a substandard dwelling up to minimum habitation standards.

**Personal Assistance Services (Agency-Directed)**

Personal Assistance services mean direct support with personal assistance, activities of daily living, community access, medication and other medical needs, and monitoring health status and physical condition. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Allowable activities include:

1. Assistance with activities of daily living (ADLs), such as: bathing or showering, toileting, routine personal hygiene skills, dressing, and transferring;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;
4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
5. Assistance with housekeeping activities, such as bed making, dusting, vacuuming, laundry, and grocery shopping, when specified in the individual's ISP and essential to the individual's health or welfare or both;
6. General support to assure the safety of the individual;

7. Assistance and support needed by the individual to participate in social, recreational, and community activities; and
8. Accompanying the individual to appointments or meetings.

***Medicaid Service Units and Service Limitations***

The unit of service for Personal Assistance services is one hour. The amount of Personal Assistance services that can be authorized is determined by the individual's assessed needs and required supports. When two individuals who live in the same home request Personal Assistance services, the provider will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks that must be provided independently, such as bathing, dressing, and ambulating. The amount of time for tasks that could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals.

**Personal Assistance Services (Consumer-Directed)**

Consumer Directed Personal Assistance (CD-PA) services mean direct assistance with personal care activities of daily living, access to the community, medication and other medical needs and monitoring health status and physical condition. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) that are incidental to the Personal Assistance services furnished or which are essential to the health and welfare of the individual. CD-PA services shall not include practical or professional nursing services as defined in the Nurse Practice Act. CD-PA services may be provided in the home or community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Allowable services are the same as agency-directed Personal Assistance Services plus

11. Assistance in the workplace with activities not already required or funded by another source (may include activities such as assistance with filing, retrieving work materials that are out of reach; providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment).

***Medicaid Service Units and Service Limitations***

Personal assistants are paid an hourly rate. The Fiscal Agent pays personal assistants on behalf of the individual once the timesheet is signed by the assistant and individual and forwarded to the Agent.

**Personal Emergency Response System**

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors individual safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices. PERS services are limited to those individuals who live alone or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and would otherwise require extensive routine supervision. Medication monitoring units must be physician-ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring services simultaneously. PERS can only be authorized when no one else is in the home who is competent or continuously available to call for help in an emergency.

***Medicaid Service Units and Service Limitations***

A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price set by DMAS. The one time installation of the unit(s) shall include installation, account activation, individual and caregiver instruction, and removal of equipment.

**Prevocational**

Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job task-oriented. They are aimed at a more generalized result. Prevocational services are provided to individuals who are not expected to join the regular work force without supports or participate in a transitional sheltered workshop program within a year (excluding supported employment programs). Prevocational services may be provided in sheltered workshop settings. Allowable activities include:

1. Training and support in skills that are aimed at preparation for paid employment offered in a variety of community settings;
2. Training and support in activities that are primarily directed at habilitative goals (e.g., attention span and motor skills);
3. Training and support in such concepts as accepting supervision, attendance, task completion, problem solving, and safety;
4. Training and support that is focused on completing assignments, solving problems, or safety;
5. Assistance with personal care;
6. Supervision to ensure the individual's health and safety; and
7. Staff coverage for transportation of the individual between training and service activity sites.

***Medicaid Service Units and Service Limitations***

Billing is for a unit of service:

- One unit is 1 to 3.99 hours of service per day. In instances where staff are required to ride with the individual to and from Prevocational activities, billing for this time cannot exceed 25 percent of the total time spent in the Prevocational activity for that day.
- Two units are 4 to 6.99 hours of service per day. In instances where staff are required to ride with the individual to and from Prevocational activities, billing for this time cannot exceed 25 percent of the total time spent in the Prevocational activity for that day; and
- Three units are 7 or more hours of service per day. In instances where staff are required to ride with the individual to and from Prevocational activities, billing for this time cannot exceed 25 percent of the total time spent in the Prevocational activity for that day; however, a minimum of 7 hours of other allowable activities must be provided in order to be reimbursed for a 3-unit day.

The ISP must provide an estimate of the amount of Prevocational required by the individual. The maximum is 780 units per consumer service plan (CSP) year.

**Residential Support Services**

Residential Support services consist of training and assistance or specialized supervision, provided primarily in an individual's home or in a licensed or approved residence considered to be his or her home, to enable the individual to acquire, improve, or maintain his or her health status and to develop skills in activities of daily living and safety in the use of community resources and adapting his or her

behavior to community and home environments. Emphasis is on a person-centered approach that empowers and supports each individual in developing his or her own lifestyle. Residential Support may not include room and board or general supervision. MR Waiver services will not be routinely provided for a continuous 24-hour period. Residential Support services may be provided as Supported Living/In-Home Supports or as Congregate Residential Support. The distinction is based on the service setting that provides the services, the ratio of staff to individual(s), and whether services are routinely provided by paid staff across a continuous 24-hour period.

Supported Living/In-Home Supports are supplemental to the primary care (i.e., room and board or general supervision) provided by a parent or similar caregiver. This service may also support an individual whose level of independence does not require a primary care provider. The usual setting is a private residence, such as a home or apartment. A Residential Support staff person comes to the residence to provide services. Supported Living/In-Home Supports are delivered on an individualized basis according to the ISP and are delivered primarily with a 1:1 staff-to-individual ratio except when training protocols require parallel or interactive intervention. Primary care and Residential Support services are not routinely provided by paid staff of the Supported Living/In-Home Supports provider across a continuous 24-hour period.

Congregate Residential Support is training, assistance and specialized supervision provided to an individual living in a group home, the home of the care provider who also provides the MR Waiver services (such as Adult Foster Care or Sponsored Placement), or an apartment or other home setting, with one or more individuals also receiving MR Waiver Residential Support services from the same staff at the same time, and delivered according to the ISP, including individual or group situations.

***Medicaid Service Units and Service Limitations***

Congregate Residential Support may be reimbursed on an average daily amount of hours established per individual. The average daily amount is determined by multiplying the total hours scheduled per week by 4.3 and dividing the results by 30. The average daily amount is used for billing purposes only. Whenever *any portion* of the training, assistance, or specialized supervision authorized in the Residential Support ISP is provided during a day, the entire average daily amount of hours may be billed. No more than 30 days per month (28/29 days in February) may be billed when billing is based on the average daily amount. Supported Living/In-Home Supports are reimbursed on an hourly basis for the time the Residential Support staff is working directly with the individual. Total billing cannot exceed the total hours authorized by the ISAR. When unavoidable circumstances occur so that a provider is at the individual's home at the designated time but cannot deliver part of the services due to individual or family related situations (such as unanticipated lateness or illness of the individual or family emergency), billing will be allowed for the *entire* number of hours scheduled for that day, as long as *some portion* of the ISP is provided.

**Respite Services (Agency-Directed)**

Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver. They are provided in an individual's home, other community residence or in other community sites. Allowable activities include:

1. Assistance with activities of daily living such as: bathing or showering, toileting, routine personal hygiene skills, dressing, and transferring;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;

4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
5. Assistance with housekeeping activities, such as bed-making, dusting and vacuuming, laundry, and grocery shopping, when specified in the individual's ISP and essential to the individual health and welfare;
6. Support to assure the safety of the individual;
7. Assistance or support, or both, needed by the individual to participate in social, recreational, or community activities; and
8. Accompanying the individual to appointments or meetings.

***Medicaid Service Units and Service Limitations***

The unit of service for Respite services is one hour. Respite services provided in any setting are limited to 720 hours per calendar year. Individuals who are receiving both consumer-directed and agency-directed Respite services cannot exceed 720 hours per calendar year combined.

**Respite Services (Consumer-Directed)**

Consumer-Directed Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for periodic or routine relief of the primary caregiver. They are provided in an individual's home, other community residence, and other community sites. Allowable activities include:

1. Assistance with personal care activities such as: bathing or showering, toileting, routine personal hygiene skills, dressing, and transferring;
2. Assistance with monitoring health status and physical condition;
3. Assistance with self-medication and other medical needs;
4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
5. Assistance with housekeeping activities, such as bed-making, dusting, vacuuming, laundry, and grocery shopping, when specified in the person's ISP and essential to his or her health and welfare;
6. Support to assure the safety of the individual;
7. Assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care;
8. Attending training requested by the individual or family member/caregiver that relates to services described in the ISP;
9. Assistance or support, or both, needed by the individual to participate in social, recreational, or community activities; and
10. Accompanying the individual to appointments or meetings.

***Medicaid Service Units and Service Limitations***

Respite assistants are paid an hourly rate. The Fiscal Agent pays respite assistants on behalf of the individual, once the timesheet is signed by the assistant and individual and forwarded to the Agent.

**Skilled Nursing Services**

Skilled nursing services are available to individuals with serious medical conditions and complex health care needs, which require specific skilled nursing services ordered by a physician and which cannot be accessed under the *State Plan for Medical Assistance*. These services must be necessary to enable an individual to live in a non-institutional setting in the community and cannot be provided by non-nursing personnel. Services are provided in an individual's home or community setting, or both, on a regularly scheduled or intermittent need basis. Allowable activities include:

1. Monitoring of an individual's medical status;
2. Administering medications and other medical treatment; or
3. Training or consultation with family members, staff, and other persons responsible for carrying out an individual's CSP to monitor the individual's medical status and to administer medications and other medically related procedures consistent with the Nurse Practice Act (Title 54.1, Code of Virginia, Subtitle III, Chapters 30 and 34).

***Medicaid Service Units and Service Limitations***

The unit of service is one hour, with no limitation on the number of hours that may be authorized. However, the Skilled Nursing services must be explicitly detailed in an ISP and must be specifically ordered by a physician as medically necessary to prevent or delay institutionalization.

**Supported Employment**

Supported Employment means work in settings in which persons without disabilities are typically employed. It is especially designed for individuals with developmental disabilities, including persons with mental retardation, facing severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without on-going supports and who because of their disability, need ongoing post-employment support to perform in a work setting.

***Models of Supported Employment***

Supported Employment can be provided in one of two models. Individual Supported Employment is defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position who, during most of the time on the job site, performs independently. Group Supported Employment is defined as continuous support provided by staff to eight or fewer individuals with disabilities in an Enclave, Work Crew, Entrepreneurial model or Benchwork model. An Entrepreneurial model of Supported Employment is a small business employing fewer than eight individuals with disabilities and usually involves interactions with the public and with co-workers without disabilities. An example of the Benchwork model is a small, nonprofit electronics assembly business that employs individuals without disabilities to work alongside eight or fewer individuals with significantly complex needs and provides daily opportunities for community integration. The individual's assessment and CSP must clearly reflect the individual's need for training and supports to acquire or maintain paid employment.

***Medicaid Service Units and Service Limitations***

Supported Employment for individual job placement will be billed on an hourly basis. It may include transportation of the person to and from work sites, not to exceed 25 percent of the total time billed. Group models of Supported Employment (Enclaves, Work Crews, Entrepreneurial and Benchwork models of Supported Employment) will be billed at the following unit rates.

Units of service:

- One unit is 1 to 3.99 hours of service a day. In instances where staff are required to ride with the individual to and from Supported Employment activities, billing for this time cannot exceed 25 percent of the total time spent in the Supported Employment activity for that day.
- Two units are 4 to 6.99 or more hours of service a day. In instances where staff are required to ride with the individual to and from Supported Employment activities, billing for this time cannot exceed 25 percent of the total time spent in the Supported Employment activity for that day.
- Three units are 7 or more hours of service a day. In instances where staff are required to ride with the individual to and from Supported Employment activities, billing for this time cannot exceed 25 percent of the total time spent in the Supported Employment activity for that day; however, a minimum of seven hours of other allowable activities must be provided in order to be reimbursed for a three-unit day.

**Therapeutic Consultation**

Therapeutic Consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are:

1. Psychology;
2. Behavioral Consultation;
3. Therapeutic Recreation;
4. Speech and Language Pathology;
5. Occupational Therapy;
6. Physical Therapy; and
7. Rehabilitation Engineering.

***Medicaid Service Units and Service Limitations***

The unit of service is one hour, with no limitation on the number of hours that may be authorized. However, the services must be explicitly detailed in an ISP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic Consultation may not be billed solely for purposes of monitoring.